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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: MISTY LYNN HORINEK 2 Kanza Lane Newkirk, Oklahoma 74647 Registered Nursing License No. 646200 Respondent.	Case No. 2009-59 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about October 8, 2004, the Board of Registered Nursing issued Registered Nursing License Number 646200 to Misty Lynn Horinek (Respondent). The Registered Nursing License was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2010, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

6. Section 2761 of the Code states, in part, as follows:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct . . .

. . .

(d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter [the Nursing Practice Act] or regulations adopted pursuant to it. . . ."

7. Section 2762 of the Code states, in pertinent part:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

. . .

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

COST RECOVERY

8. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CONTROLLED SUBSTANCES / DANGEROUS DRUGS

9. Dilaudid is a trade name for Hydromorphone, an Opium derivative, which is classified as a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(k), and is a dangerous drug within the meaning of Business and Professions Code section 4022.

10. Morphine / Morphine Sulfate, a narcotic substance, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(M) and is categorized as a dangerous drug pursuant to Business and Professions Code section 4022.

11. Demerol, a brand of meperidine hydrochloride, a derivative of the narcotic substance pethidine, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (c)(17), and is categorized as a dangerous drug pursuant to Business and Professions Code section 4022.

12. Fentanyl is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c)(8), and is a dangerous drug pursuant to Business and Professions Code section 4022.

13. Versed is a water soluble benzodiazepine Schedule IV controlled substance as defined in Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

14. Ativan, a brand name for Lorazepam, is a Schedule IV controlled

substance as defined in Health and Safety Code section 11057, subdivision (d)(16), and a dangerous drug pursuant to Business and Professions Code section 4022.

I. Lakewood Regional Medical Center

15. On or about October 23, 2006, Respondent was sent by MGA Healthcare Staffing, Inc., a nursing registry, to Lakewood Regional Medical Center. Respondent was assigned, as a registered nurse, to the Emergency Department (ED) at Lakewood Regional Medical Center and worked the 6:00 a.m. to 6:30 p.m. shift. Lakewood Regional Medical Center utilized an automated single unit dosage medication dispensing system named "Sure Med" that recorded information such as the patient's name, physician, physician orders, date and time of medication withdrawn and the name of the licensed individual who withdrew and administered the medication.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

16. Respondent is subject to disciplinary action under Code sections 2750, 2761, subdivisions (a) and (d), in conjunction with section 2762, on the grounds of unprofessional conduct in that Respondent obtained or possessed, in violation of law, controlled substances and / or dangerous drugs. The circumstances are as follows:

a) Patient "A"[1] was treated in the ED on or about October 23, 2006 for conjunctivitis of the eye. Respondent was not assigned to care for Patient A. Patients with conjunctivitis do not normally receive morphine for this condition and, on October 23, 2006, Patient A did not have a physician's order for morphine.

b) On or about October 23, 2006, Respondent obtained 8 mg of morphine for Patient A. Respondent obtained the first 4 mg of morphine at about 9:09 a.m. and the second 4 mg of morphine at about 12:57 p.m. Patient A was discharged from the ED at about 12:49 p.m.

c) Patient "B" was also treated in the Lakewood Regional Medical Center ED on or about October 23, 2006. The medical records indicate that Patient B had a one time

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1. The patient's identities have been redacted to protect their privacy.

physician's order for 1 mg of Dilaudid. This one time dose was administered by another registered nurse at 2:08 p.m.

d) Respondent was not assigned to care for Patient B on October 23, 2006. At about 5:06 p.m., Respondent obtained 2 mg of Dilaudid for Patient B. Respondent failed to document administering this medication to Patient B in any patient record.

e) Patient "C" was also treated in the ED on or about October 23, 2006. Patient C did not have a physician order for morphine and Respondent was not assigned to care for this patient. On or about October 23, 2006, Respondent obtained 4 mg of morphine for Patient C. Respondent failed to document administering the morphine to Patient C in any patient record.

f) Patient "D" was also treated in the ED on or about October 23, 2006. At about 8:20 p.m., the physician ordered a one time administration of 4 mg of morphine IVP. Respondent, who was not assigned to care for Patient D, obtained 4 mg of morphine for this patient at 6:50 p.m., *i.e.,* almost one hour and twenty minutes prior to the issuance of the physician's order. Respondent failed to document administering the morphine to Patient D in any patient record.

SECOND CAUSE FOR DISCIPLINE

(Unlawfully Obtained and / or Possessed Controlled Substances and / or Dangerous Drugs)

17. Respondent is subject to disciplinary action under Code sections 2750 and 2762, subdivision (a), in that Respondent obtained and/or possessed controlled substances and / or dangerous drugs, as more fully set forth above in paragraph 16.

THIRD CAUSE FOR DISCIPLINE

(Falsified or Grossly Inconsistent Patient / Hospital Records)

18. Respondent is subject to disciplinary action under Code sections 2750, 2761, subdivision (a), and 2762, subdivision (e), in that Respondent made false, grossly incorrect, grossly inconsistent, or unintelligible entries in hospital and patient records, as more fully set forth above in paragraphs 16 and 17.

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II. **Foothill Presbyterian Hospital**

19. On or about December 11, 2006, Respondent was sent by Secure Nursing Service, Inc., a nursing registry, to Foothill Presbyterian Hospital located in Glendora, California. Respondent was assigned, as a registered nurse, to work a 7:00 a.m. to 7:00 p.m. shift. Among the patients Respondent was assigned to care for on or about December 11th were Patient A.M. and Patient U. H.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

20. Respondent is subject to disciplinary action under Code sections 2750, 2761, subdivisions (a) and (d), in conjunction with section 2762, on the grounds of unprofessional conduct in that Respondent obtained or possessed, in violation of law, controlled substances and / or dangerous drugs. The circumstances are as follows:

a) On or about December 11, 2006, Respondent removed 50 mg of Demerol for Patient A.M. The Narcotics Log indicated that Respondent removed the Demerol at 8:00 a.m. Patient A.M. did not have a physician's order for Demerol and Respondent removed the Demerol without a physician's order.

b) Respondent document in the Medication Administration Record (MAR) that she administered the Demerol to Patient A.M. at 10:40 a.m. Respondent did not document giving the Demerol to Patient A.M. in the Nursing Notes for the patient.

c) Patient U.H. was assigned to Respondent on or about December 11, 2006. Patient U.H. had a physician's order for morphine 2 mg, every fours for pain. The Narcotics Log indicated that on December 11, 2006, Respondent removed morphine for Patient U.H. as follows: 2 mg at 8:00 a.m.; 4 mg at 12:00 p.m.; and 4 mg at 4:00 p.m.. Respondent documented on the MAR that she administered 4 mg morphine to Patient U.H. as follows: 4 mg at 8:00 a.m.; 2 mg at 12:00 p.m.; and 2 mg at 4:05 p.m.. Respondent did not document giving the morphine to Patient U.H. in the Nursing Notes for the patient.

d) At the December 11, 2006 shift change, Respondent reported to the on coming nurse, that Patient U.H. was in pain. Respondent informed the nurse that she had to

medicate Patient U.H. with morphine 2 mg IVP more than once. When the on coming nurse did her rounds, she asked Patient U.H. if she was still in pain. The patient said no, she was not in pain, and had not received any pain medication that day.

FIFTH CAUSE FOR DISCIPLINE

(Unlawfully Obtained and / or Possessed Controlled Substances and / or Dangerous Drugs)

21. Respondent is subject to disciplinary action under Code sections 2750 and 2762, subdivision (a), in that Respondent obtained and/or possessed controlled substances and / or dangerous drugs, as more fully set forth above in paragraph 20.

SIXTH CAUSE FOR DISCIPLINE

(Falsified or Grossly Inconsistent Patient / Hospital Records)

22. Respondent is subject to disciplinary action under Code sections 2750, 2761, subdivision (a), and 2762, subdivision (e), in that Respondent made false, grossly incorrect, grossly inconsistent, or unintelligible entries in hospital and patient records, as more fully set forth above in paragraphs 20 and 21.

III. Little Company of Mary San Pedro Hospital

23. On or about February 14, 2007, Respondent was send by a nursing registry service, to work at Little Company of Mary San Pedro Hospital. Respondent was assigned, as a registered nurse, to the Critical Care Unit (CCU) and worked the 7:00 a.m. to 7:30 p.m. shift. Little Company of Mary San Pedro Hospital utilized an automated single unit dosage medication dispensing system named "Pyxis" that recorded information such as the patient's name, physician, physician orders, date and time of medication withdrawn and the name of the licensed individual who withdrew and administered the medication.

SEVENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

24. Respondent is subject to disciplinary action under Code sections 2750, 2761, subdivisions (a) and (d), in conjunction with section 2762, on the grounds of unprofessional conduct in that Respondent obtained or possessed, in violation of law, controlled substances and / or dangerous drugs. The circumstances are as follows:

a) On February 13, 2007, Patient A had a physician's order for Morphine Sulfate 2 mg, every two hours, as needed for pain. At about 12:54 p.m., on February 14, 2007, Respondent removed 4 mg of Morphine Sulfate from the Pyxis machine for Patient A. Respondent was not assigned to care for Patient A on February 13, 2007. Respondent failed to document in either the MAR or the Nursing Notes for Patient A that she administered the medication to Patient A.

b) On or about February 14, 2007, Patient B had a physician's order for Morphine Sulfate 2 mg IVP every four hours, as needed for moderate pain, 4 mg IVP every four hours, as needed for severe pain. Respondent was not assigned to care for patient B.

c) On or about February 14, 2007, Respondent removed 4 mg of Morphine Sulfate for Patient B from the Pyxis machine at 1:39 p.m. and another 4 mg of Morphine Sulfate at 4:00 p.m.. Respondent failed to wait four hours before the 4:00 p.m dosage of Morphine Sulfate as required by the physician's order. Respondent documented in the MAR that she administered 4 mg of Morphine Sulfate to Patient B at 1:30 p.m. and 4 my of Morphine Sulfate to Patient B at 4:15 p.m..Respondent failed to document in the Nursing Notes for Patient B that she administered the medication to the patient.

EIGHTH CAUSE FOR DISCIPLINE

(Unlawfully Obtained and / or Possessed Controlled Substances and / or Dangerous Drugs)

25. Respondent is subject to disciplinary action under Code sections 2750 and 2762, subdivision (a), in that Respondent obtained and/or possessed controlled substances and / or dangerous drugs, as more fully set forth above in paragraph 24.

NINTH CAUSE FOR DISCIPLINE

(Falsified or Grossly Inconsistent Patient / Hospital Records)

26. Respondent is subject to disciplinary action under Code sections 2750, 2761, subdivision (a), and 2762, subdivision (e), in that Respondent made false, grossly incorrect, grossly inconsistent, or unintelligible entries in hospital and patient records, as more fully set forth above in paragraphs 24 and 25.

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IV. HealthCare Partners Medical Group

27. In June, 2007, Respondent was sent by Mediscan Nursing Staffing, Inc., a nurse registry, to HealthCare Partners Medical Group to work as a registered nurse.

TENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

28. Respondent is subject to disciplinary action under Code sections 2750, 2761, subdivisions (a) and (d), in conjunction with section 2762, on the grounds of unprofessional conduct in that Respondent obtained or possessed, in violation of law, controlled substances and / or dangerous drugs. The circumstances are as follows:

a) Patient A had a physician's order for Morphine Sulfate 2 - 4 mg every hour, as needed for pain. On or about June 29, 2007, Respondent removed a total of 30 mg of Morphine for Patient A and wasted 6 mg, leaving 24 mg of Morphine to be administered to Patient A. Respondent documented the following administration of Morphine for Patient A: 12:45 p.m. - Morphine 4 mg IVP and 2:15 p.m. - Morphine 4 mg IVP. Respondent failed to account for 16 mg of Morphine for Patient A.

b) On or about June 19, 2007, Patient B was to undergo conscious sedation for the purpose of performing a medical procedure. The physician's orders were for Fentanyl 200 mg and Versed 10 mg for the procedure. Respondent documented removing a total of 400 mg of Fentanyl for Patient B and administering a total of 250 mg of Fentanyl for Patient B. Respondent failed to account for 150 mg of Fentanyl. Respondent documented removing a total of 15 mg of Versed for Patient B and administering a total of 20 mg of Versed for Patient B.

c) On or about June 30, 2007, Patient C had a physician order for Ativan 1 mg IV. Respondent removed a total of 4 mg of Ativan for Patient C on June 30, 2007. Respondent documented administering 1 mg of Ativan IV to Patient C. Respondent failed to account for 3 mg of Ativan.

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ELEVENTH CAUSE FOR DISCIPLINE

(Unlawfully Obtained and / or Possessed Controlled Substances and / or Dangerous Drugs)

29. Respondent is subject to disciplinary action under Code sections 2750 and 2762, subdivision (a), in that Respondent obtained and/or possessed controlled substances and / or dangerous drugs, as more fully set forth above in paragraph 28.

TWELVETH CAUSE FOR DISCIPLINE

(Falsified or Grossly Inconsistent Patient / Hospital Records)

29. Respondent is subject to disciplinary action under Code sections 2750, 2761, subdivision (a), and 2762, subdivision (e), in that Respondent made false, grossly incorrect, grossly inconsistent, or unintelligible entries in hospital and patient records, as more fully set forth above in paragraphs 28 and 29.

V. White Memorial Medical Center

30. In September 2007, Respondent was sent by World Class Medical Staffing, a nursing registry, to White Memorial Medical Center in Los Angeles, California. Respondent was assigned, as a registered nurse, to the Emergency Department (ED). Respondent's last day of work at White Memorial Medical Center was November 8, 2007. White Memorial Medical Center utilized an automated single unit dosage medication dispensing system named "Omnicell" that recorded information such as the patient's name, physician, physician orders, date and time of medication withdrawn and the name of the licensed individual who withdrew and administered the medication.

THIRTEENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

31. Respondent is subject to disciplinary action under Code sections 2750, 2761, subdivisions (a) and (d), in conjunction with section 2762, on the grounds of unprofessional conduct in that Respondent obtained or possessed, in violation of law, controlled substances and / or dangerous drugs. The circumstances are as follows:

a) On or about October 28, 2007, Respondent obtained 4 ML of Fentanyl for Patient 1 as follows: Omnicell records indicate that Respondent obtained 2 ML at 1:15 a.m. and

2 ML at 2:45 a.m. Patient 1 did not have a physician's order for Fentanyl, nor was Respondent assigned to care for Patient 1 on October 28, 2007. Patient 1 was discharged from White Memorial Medical Center at 1:16 a.m.. Respondent failed to document administration of the Fentanyl.

b) On or about October 28, 2007, Respondent obtained 2 ML of Fentanyl for Patient 2. Patient 2 did not have a physician's order for Fentanyl, nor was Respondent assigned to care for Patient 2 on October 28, 2007. Respondent failed to document or account for the Fentanyl obtained for Patient 2. Patient 2 did have a one time order for Dilaudid 1 mg. Omnicell records indicate that Respondent obtained a total of 7 mg of Dilaudid for Patient 2. Respondent documented administration of 1 mg of Dilaudid to Patient 2 at 6:15 p.m. Respondent failed to account for 7 mg of Dilaudid.

c) On or about October 28, 2007, Respondent obtained 2 ML of Fentanyl for Patient 3. Patient 3 did not have a physician's order for Fentanyl, nor was Respondent assigned to care for Patient 3 on October 28, 2007. Respondent failed to document or account for the Fentanyl obtained for Patient 3.

d) On or about October 29, 2007, Respondent obtained 2 ML of Fentanyl for Patient 5. Patient 5 did not have a physician's order for Fentanyl, nor was Respondent assigned to care for Patient 5 on October 29, 2007. Respondent failed to document or account for the Fentanyl obtained for Patient 5.

e) Patient 6 had a physician's order for Dilaudid, 1 mg IVP - one time. On or about October 29, 2007, Respondent obtained 5 mg of Dilaudid for Patient 6. Respondent was not assigned to care for Patient 6 on October 29, 2007 and Respondent to document or account for the Dilaudid obtained for Patient 6.

f) On or about October 30, 2007, Respondent obtained 4 ML of Fentanyl for Patient 7. Patient 7 did not have a physician's order for Fentanyl, nor was Respondent assigned to care for Patient 7 on October 30, 2007. Respondent failed to document or account for the Fentanyl obtained for Patient 7.

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g) On or about October 30, 2007, Respondent obtained 2 ML of Fentanyl for Patient 8. Patient 8 did not have a physician's order for Fentanyl, nor was Respondent assigned to care for Patient 8 on October 30, 2007. Respondent failed to document or account for the Fentanyl obtained for Patient 8. Patient 8 did have a physician's order for Dilaudid 1 mg IVP - one time. On or about October 30, 2007, Respondent obtained 5 mg of Dilaudid for Patient 8. Respondent documented in the Emergency Nursing Records administering 1 mg of Dilaudid at 6:00 p.m. Respondent failed to account for 4 mg of Dilaudid.

h) On or about October 30, 2007, Respondent obtained 2 ML of Fentanyl for Patient 9. Patient 9 did not have a physician's order for Fentanyl, nor was Respondent assigned to care for Patient 9 on October 30, 2007. Omnicell records indicate that Respondent wasted 1 ML of Fentanyl; however, that is was no witness to the wastage.

i) On or about November 5, 2007, Respondent obtained 2 ML of Fentanyl for Patient 10. Patient 10 did not have a physician's order for Fentanyl, nor was Respondent assigned to care for Patient 10 on November 5, 2007. Respondent failed to document or account for the Fentanyl obtained for Patient 10.

j) On or about November 6, 2007, Respondent obtained 4 mg of Dilaudid for Patient 12. Patient 12 did not have a physician's order for Dilaudid, nor was Respondent assigned to care for Patient 12 on November 6, 2007. Respondent failed to document or account for the Dilaudid obtained for Patient 12.

k) On or about November 6, 2007, Respondent obtained 2 ML of Fentanyl and 2 mg of Dilaudid for Patient 13. Patient 13 did not have a physician's order for either Fentanyl or Dilaudid on November 6, 2007. Respondent failed to document or account for both the Fentanyl and Dilaudid obtained for Patient 13.

l) On or about November 8, 2007, Respondent obtained 2 ML of Fentanyl for Patient 14. Patient 14 did not have a physician's order for Fentanyl. Omnicell records indicate that Respondent wasted the 2 ML of Fentanyl obtained for Patient 14; however, there is no witness listed to the wastage in the Omnicell records.

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j) On or about November 8, 2007, Respondent obtained 1 mg of Dilaudid for Patient 15. Patient 15 did not have a physician's order for Dilaudid, nor was Respondent assigned to care for Patient 15 on November 8, 2007. Respondent failed to document or account for the Dilaudid obtained for Patient 15.

FOURTEENTH CAUSE FOR DISCIPLINE

(Unlawfully Obtained and / or Possessed Controlled Substances and / or Dangerous Drugs)

32. Respondent is subject to disciplinary action under Code sections 2750 and 2762, subdivision (a), in that Respondent obtained and/or possessed controlled substances and / or dangerous drugs, as more fully set forth above in paragraph 31.

FIFTEENTH CAUSE FOR DISCIPLINE

(Falsified or Grossly Inconsistent Patient / Hospital Records)

33. Respondent is subject to disciplinary action under Code sections 2750, 2761, subdivision (a), and 2762, subdivision (e), in that Respondent made false, grossly incorrect, grossly inconsistent, or unintelligible entries in hospital and patient records, as more fully set forth above in paragraphs 31 and 32.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nursing License Number 646200, issued to Misty Lynn Horinek;

2. Ordering Misty Lynn Horinek to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 9/16/08

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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